		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040303

Facility Name: PRAIRIE VIEW CARE CENTER-LEWISTOWN

Address: 175 E. SYCAMORE (Number) LEWISTOWN (City) 61542 (Zip Code)

County: FULTON

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 37-1304214

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) VICE PRESIDENT

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,254	1,254	8
9	SNF/PED					9
10	ICF	20,056	2,787	314	23,157	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,056	2,787	1,568	24,411	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.37%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,254

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTO # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	108,269	6,126	4,984	119,379		119,379		119,379			1
2	Food Purchase		120,562		120,562		120,562	(332)	120,230			2
3	Housekeeping	97,942	16,097		114,039		114,039	75	114,114			3
4	Laundry	23,808	11,017		34,825		34,825		34,825			4
5	Heat and Other Utilities			57,122	57,122		57,122		57,122			5
6	Maintenance	25,537	7,246	10,702	43,485		43,485	42	43,527			6
7	Other (specify):*			4,200	4,200		4,200		4,200			7
8	**TOTAL General Services**	255,556	161,048	77,008	493,612		493,612	(215)	493,397			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	820,258	57,937	29,768	907,963		907,963	12,778	920,741			10
10a	Therapy	36,729	2,566	1,231	40,526		40,526		40,526			10a
11	Activities	43,704	1,045	907	45,656		45,656		45,656			11
12	Social Services	41,143			41,143		41,143		41,143			12
13	Nurse Aide Training											13
14	Program Transportation			665	665		665		665			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	941,834	61,548	32,571	1,035,953		1,035,953	12,778	1,048,731			16
	C. General Administration											
17	Administrative	46,952		12,000	58,952		58,952	22,902	81,854			17
18	Directors Fees											18
19	Professional Services			89,470	89,470		89,470	(30,326)	59,144			19
20	Dues, Fees, Subscriptions & Promotions			13,670	13,670		13,670	(8,103)	5,567			20
21	Clerical & General Office Expenses	54,906	9,322	113,912	178,140		178,140	(18,374)	159,766			21
22	Employee Benefits & Payroll Taxes			210,895	210,895		210,895	16,805	227,700			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,938	1,938		1,938	6,322	8,260			24
25	Other Admin. Staff Transportation			10,734	10,734		10,734	8,063	18,797			25
26	Insurance-Prop.Liab.Malpractice			58,725	58,725		58,725	2,317	61,042			26
27	Other (specify):*											27
28	**TOTAL General Administration**	101,858	9,322	511,344	622,524		622,524	(394)	622,130			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,299,248	231,918	620,923	2,152,089		2,152,089	12,169	2,164,258			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PRAIRIE VIEW CARE CENTER-LEWISTOWN #0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,984	
	REPAIRS & MAINTENANCE		0	
			0	4,984
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		0	
	ELECTRICITY		48,423	
	WATER		8,181	
	CABLE TV - LOBBY		518	
			0	57,122
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,971	
	PAINTING & DECORATING		62	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,457	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		955	
	FIRE SERVICE		1,257	
			0	
			0	
			0	10,702
7	**OTHER**			
	SCAVENGER		4,200	
	SECURITY SERVICE		0	4,200
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	24,761	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		582	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	3,626	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	574	
	PHARMACY CONSULTANT	XVIII B 39-2	225	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	29,768
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		120	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		26	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	1,085	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,231
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	907	
			0	907
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN #0040303 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		665	665
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	12,000	12,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,834	
	ADMINISTRATIVE CONSULTANTS	XIX C	32,400	
	PROFESSIONAL FEES	XIX C	51,236	
			0	89,470
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,405	
	EMPLOYEE WANT ADS	XIX F	1,686	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	361	
	LICENSES & PERMITS	XIX F	3,492	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,726	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	13,670
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		2,166	
	OUTSIDE CLERICAL SERVICES		95,721	
	PENALTIES / OVERDRAFT CHARGES	VI 18	6,154	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		180	
	TELEPHONE		7,595	
	MESSENGER SERVICE		2,096	
			0	113,912

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	94,795	
	UNEMPLOYMENT COMPENSATION	XIX D	24,557	
	WORKERS COMPENSATION INSURANCI	XIX D	51,784	
	HOSPITALIZATION INSURANCE	XIX D	37,028	
	EMPLOYEE BENEFITS - OTHER	XIX D	627	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,104	
	CHICAGO HEAD TAX	XIX D	0	210,895
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	965	
	TRAVEL	XIX G	973	
			0	
			0	1,938
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,734	10,734
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		58,725	58,725
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 620,923

PRAIRIE VIEW CARE CENTER-LEWISTOWN
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	120,562	PATIENT MEALS	73233
LESS SALES TAX	(332)	ADD EMPLOYEE MEALS	0
NET FOOD	120,230	TOTAL MEALS/YEAR	73233
TOTAL PATIENT CENSUS	24,411	NET FOOD	120230
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	73233
TOTAL PATIENT MEALS	73233	COST PER MEAL	1.64
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN #0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,180	20,180		20,180	111,598	131,778			30
31	Amortization of Pre-Op. & Org.							7,357	7,357			31
32	Interest			85,197	85,197		85,197	150,783	235,980			32
33	Real Estate Taxes			23,587	23,587		23,587	(73)	23,514			33
34	Rent-Facility & Grounds			228,352	228,352		228,352	(223,524)	4,828			34
35	Rent-Equipment & Vehicles			3,431	3,431		3,431	360	3,791			35
36	Other (specify):*											36
37	**TOTAL Ownership**			360,747	360,747		360,747	46,501	407,248			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,212	58,646	113,858		113,858		113,858			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		55,212	112,998	168,210		168,210		168,210			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,299,248	287,130	1,094,668	2,681,046		2,681,046	58,670	2,739,716			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,442	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(332)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(6,154)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,405)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,726)	20		28
29	Other-Attach Schedule	(73)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (13,248)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	71,918		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 71,918		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 58,670		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PRAIRIE VIEW CARE CENTER-LEWISTOWN

ID# 0040303

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	REAL ESTATE TAX ADJ	(73)	33	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(332)	0	0	0	0	0	0	0	0	0	0	(332)	2
3	Housekeeping	0	0	75	0	0	0	0	0	0	0	0	75	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	42	0	0	0	0	0	0	0	0	42	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(332)	0	117	0	0	0	0	0	0	0	0	(215)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	12,778	0	0	0	0	0	0	0	0	12,778	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	12,778	0	0	0	0	0	0	0	0	12,778	16
	C. General Administration													
17	Administrative	0	(12,000)	34,902	0	0	0	0	0	0	0	0	22,902	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(32,400)	2,074	0	0	0	0	0	0	0	0	(30,326)	19
20	Fees, Subscriptions & Promotions	(8,131)	0	28	0	0	0	0	0	0	0	0	(8,103)	20
21	Clerical & General Office Expenses	(6,154)	(92,361)	80,141	0	0	0	0	0	0	0	0	(18,374)	21
22	Employee Benefits & Payroll Taxes	0	0	16,805	0	0	0	0	0	0	0	0	16,805	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,322	0	0	0	0	0	0	0	0	6,322	24
25	Other Admin. Staff Transportation	0	0	8,063	0	0	0	0	0	0	0	0	8,063	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,317	0	0	0	0	0	0	0	0	2,317	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,285)	(136,761)	150,652	0	0	0	0	0	0	0	0	(394)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,617)	(136,761)	163,547	0	0	0	0	0	0	0	0	12,169	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,442	108,331	1,825	0	0	0	0	0	0	0	0	111,598	30
31	Amortization of Pre-Op. & Org.	0	7,357	0	0	0	0	0	0	0	0	0	7,357	31
32	Interest	0	150,783	0	0	0	0	0	0	0	0	0	150,783	32
33	Real Estate Taxes	(73)	0	0	0	0	0	0	0	0	0	0	(73)	33
34	Rent-Facility & Grounds	0	(228,352)	4,828	0	0	0	0	0	0	0	0	(223,524)	34
35	Rent-Equipment & Vehicles	0	0	360	0	0	0	0	0	0	0	0	360	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,369	38,119	7,013	0	0	0	0	0	0	0	0	46,501	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(13,248)	(98,642)	170,560	0	0	0	0	0	0	0	0	58,670	45

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MGMT	SKOKIE	BKKPG/MGMT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 12,000	CERTIFIED HEALTH MGMT		$	$ (12,000)	1
2	V	21	BOOKKEEPING	95,721				(95,721)	2
3	V	19	ADMIN CONSULTING FEES	32,400				(32,400)	3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	228,352	PRAIRIE VIEW CARE CENTER OF LEWISTOWN LLC			(228,352)	7
8	V	21	OFFICE EXPENSE		" "		3,360	3,360	8
9	V	30	DEPRECIATION		" "		108,331	108,331	9
10	V	31	AMORTIZATION		" "		7,357	7,357	10
11	V	32	INTEREST		" "		150,783	150,783	11
12	V								12
13	V								13
14	Total			$ 368,473			$ 269,831	$ * (98,642)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 75	$ 75	15
16	V	5	ELECTRIC & GAS		" " "		0		16
17	V	6	MAINTENANCE		" " "		42	42	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		12,778	12,778	18
19	V	17	ADMIN SALARIES		" " "		34,902	34,902	19
20	V	19	PROFESSIONAL FEES		" " "		2,074	2,074	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		28	28	21
22	V	21	OFFICE EXP.		" " "		80,141	80,141	22
23	V	22	EMPLOYEE BENEFITS		" " "		16,805	16,805	23
24	V	24	TRAVEL/SEMINAR		" " "		6,322	6,322	24
25	V	25	TRANSPORTATION		" " "		8,063	8,063	25
26	V	26	INSURANCE		" " "		2,317	2,317	26
27	V	30	DEPRECIATION		" " "		1,825	1,825	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		4,828	4,828	29
30	V	35	EQUIPMENT RENTAL		" " "		360	360	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 170,560	$ * 170,560	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWIST # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 10,270	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,270		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	244,189	8	$ 750	$	24,411	$ 75	1
2	5	ELECTRIC & GAS	" " "	244,189	8	0		24,411	0	2
3	6	MAINTENANCE	" " "	244,189	8	420		24,411	42	3
4	10	NURSING/MEDICAL RECORDS	" " "	244,189	8	127,817	127,817	24,411	12,778	4
5	17	ADMIN SALARIES	" " "	244,189	8	349,136	349,136	24,411	34,902	5
6	19	PROFESSIONAL FEES	" " "	244,189	8	20,751		24,411	2,074	6
7	20	FEE, SUBSCRIPTIONS	" " "	244,189	8	285		24,411	28	7
8	21	OFFICE EXP.	" " "	244,189	8	801,665	683,000	24,411	80,141	8
9	22	EMPLOYEE BENEFITS	" " "	244,189	8	168,109		24,411	16,805	9
10	24	TRAVEL/SEMINAR	" " "	244,189	8	63,242		24,411	6,322	10
11	25	TRANSPORTATION	" " "	244,189	8	80,653		24,411	8,063	11
12	26	INSURANCE	" " "	244,189	8	23,179		24,411	2,317	12
13	30	DEPRECIATION	" " "	244,189	8	18,257		24,411	1,825	13
14	32	INTEREST	" " "	244,189	8	0		24,411	0	14
15	34	OFFICE RENT	" " "	244,189	8	48,291		24,411	4,828	15
16	35	EQUIPMENT RENTAL	" " "	244,189	8	3,606		24,411	360	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,706,161	$ 1,159,953		$ 170,560	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRAIRIE VIEW CARE CENTER OF LEWISTC
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 108,331	$	1	$ 108,331	1
2	31	AMORTIZATION		1	1	7,357		1	7,357	2
3	32	INTETEST		1	1	150,783		1	150,783	3
4	21	OFFICE EXP		1	1	3,360		1	3,360	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 269,831	$		$ 269,831	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTC # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANK FINANCIAL		X	MORTGAGE	$12,300.00	05/03	$	$ 1,720,794	05/09	PRIME+	$ 119,170	1
2	GERSON BASSMAN	X		MORTGAGE				796,287		8.9000	22,694	2
3	BANK FINANCIAL		X	MORTGAGE	$3,837.00			146,382		PRIME+	8,919	3
4	5TH 3RD BANK		X	WORKING CAPITAL	$10,000.00			199,083			13,852	4
5	OFFICERS LOANS	X						1,186,709			33,877	5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				350,000		PRIME+	6,034	6
7	BANK FINANCIAL		X	WORKING CAPITAL-LOC				503,031			29,511	7
8	INSURANCE FINANCING		X	INS FINANCING							1,923	8
9	TOTAL Facility Related				$26,137.00		$	$ 4,902,286			$ 235,980	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 4,902,286			$ 235,980	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 21,820	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 22,444	2
3. Under or (over) accrual (line 2 minus line 1).		$ 624	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 22,890	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 23,514	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	21,434	8
	2000	21,428	9
	2001	21,320	10
	2002	21,396	11
	2003	22,444	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRAIRIE VIEW CARE CENTER-LEWISTOWN COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0040303

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-19-27-141-004	NURSING HOME	$ 22,443.82	$ 22,443.82
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,443.82	$ 22,443.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 148,500	1
2					2
3	TOTALS			$ 148,500	3

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2000		$ 2,673,000	$ 97,200	27.5	$ 97,200	$	$ 494,014	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AUTO SPRINKLER			1993	17,150	439	39	440	1	4,851	9
10	CONDENSOR			1993	2,414	62	39	62	(0)	710	10
11	EXPANDER			1993	6,354	163	39	163	(0)	1,827	11
12	NEW DOOR			1993	620	16	39	16	(0)	182	12
13	FIRE ALARM			1994	6,942	178	39	178		1,951	13
14	CIBICLE TRACKS/CURTAINS			1994	8,149	209	39	209	(0)	2,256	14
15	ARCHITECH CONSULTING			1994	1,050	27	39	27	(0)	282	15
16	TILE			1995	1,113	29	39	29	(0)	286	16
17	REPLACE SHINGLES			1997	1,075	28	39	28	(0)	212	17
18	MODIFIED BITUMEN RUBBER PLUMPING/TILES			1997	13,173	338	39	338	(0)	2,606	18
19	INSTALL METALCAP			1997	2,670	68	39	68	0	519	19
20	ROOF REPAIR			1998	12,640	324	39	324	0	2,093	20
21	FLOOR TILE			1998	8,800	226	39	226	(0)	1,384	21
22	BATHROOM & CEILING REMODELING			1999	18,947	486	39	486	(0)	2,817	22
23	LANDSCAPING			1999	2,935	196	15	196	(0)	1,078	23
24	BOILER REPAIR			2000	2,159	308	7	308	0	1,761	24
25	NEW ROOF WEST WING			2000	6,000	218	27.5	218	0	899	25
26	FAUCETS FOR KITCHEN			2001	1,107	40	27.5	40	0	159	26
27	KITCHEN SINK			2001	1,671	61	27.5	61	(0)	231	27
28	A/C UNITS			2001	2,115	77	27.5	77	(0)	279	28
29	BUMPER GUARDS			2001	5,460	198	27.5	199	1	655	29
30	WALLPAPER			2001	2,708	387	7	387	(0)	1,548	30
31	DOORS 200/300 HALLS			2002	1,750	64	27.5	64	(0)	160	31
32	ZONE FIRE CONTROL			2003	1,402	51	27.5	51	(0)	96	32
33	WALLCOVERING/BUMPER GUARDS			2003	11,023	4,189	5	2,205	(1,984)	3,307	33
34	WINDOW TREATMENTS			2004	1,218	22	27.5	22	0	22	34
35	TILE/BASE COVE			2004	6,014	109	27.5	109	0	109	35
36	WALLCOVERING			2004	6,467	97	27.5	118	21	118	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,826,126	$ 105,810		$ 103,846	$ (1,964)	$ 526,409	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 76,212	$ 5,915	$ 11,291	$ 5,376	5-7 YRS	$ 36,628	71
72	Current Year Purchases	7,461	4,477	746	(3,731)	5	746	72
73	Fully Depreciated Assets	58,337					58,337	73
74			12,956	12,956				74
75	TOTALS	$ 142,010	$ 23,348	$ 24,993	$ 1,645		$ 95,711	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT, NURSING, ACTV			$ 20,436	$ 1,177	$ 2,044	$ 867	5	$ 20,436	76
77	MAINT, NURSING, ACTV	1985 DODGE VAN	1999	4,476	1	895	894	5	4,476	77
78										78
79										79
80	TOTALS			$ 24,912	$ 1,178	$ 2,939	$ 1,761		$ 24,912	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,141,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,336	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,778	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,442	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 647,032	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,431 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 28,781	$		$ 28,781	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,341			4,341	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			25,524			25,524	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				29,302		29,302	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES & Other (specify): LABORATORY	39-2					25,910		25,910	13
14	TOTAL			$		$ 58,646	$ 55,212		$ 113,858	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,678)	706,080		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,609		6
7	Other Prepaid Expenses	4,771		7
8	Accounts Receivable (owners or related parties)	(1,844)		8
9	Other(specify): R/E TAX ESCROW	7,958		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 735,574	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	153,124		15
16	Equipment, at Historical Cost	167,220		16
17	Accumulated Depreciation (book methods)	(189,775)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 130,569	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 866,143	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 381,554	$	26
27	Officer's Accounts Payable	1,186,709		27
28	Accounts Payable-Patient Deposits	500		28
29	Short-Term Notes Payable	2,876,323		29
30	Accrued Salaries Payable	11,095		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,453		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,890		32
33	Accrued Interest Payable	84,925		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,570,449	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,570,449	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,704,306)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 866,143	$	48

*(See instructions.)

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,499,907)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,499,907)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,399)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (204,399)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,704,306)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,383,344	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,383,344	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,096	6
7	Oxygen	19,185	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 93,281	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,476,647	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	493,612	31
32	Health Care	1,035,953	32
33	General Administration	622,524	33
	B. Capital Expense		
34	Ownership	360,747	34
	C. Ancillary Expense		
35	Special Cost Centers	113,858	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,681,046	40
41	**Income before Income Taxes (line 30 minus line 40)****	(204,399)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (204,399)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,080	$ 46,916	$ 22.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,456	2,476	49,963	20.18	3
4	Licensed Practical Nurses	12,337	12,827	232,731	18.14	4
5	Nurse Aides & Orderlies	37,463	38,175	436,251	11.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,896	2,172	36,729	16.91	8
9	Activity Director	3,256	3,533	29,835	8.44	9
10	Activity Assistants	1,761	1,810	13,869	7.66	10
11	Social Service Workers	3,065	3,273	41,143	12.57	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	26,489	12.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,239	9,554	65,759	6.88	15
16	Dishwashers	2,227	2,598	16,021	6.17	16
17	Maintenance Workers	1,969	2,137	25,537	11.95	17
18	Housekeepers	11,635	12,367	97,942	7.92	18
19	Laundry	2,843	3,083	23,808	7.72	19
20	Administrator	1,411	1,475	46,952	31.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,947	2,145	28,759	13.41	23
24	Clerical	1,992	2,080	26,147	12.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,140	23,166	10.83	31
32	Other Health C: CARE PLAN COO	1,985	1,985	31,231	15.73	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,466	107,990	$ 1,299,248 *	$ 12.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	125	$ 4,984	1-3	35
36	Medical Director		0	9-3	36
37	Medical Records Consultant	20	574	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	10	225	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	20	1,085	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	30	907	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	205	$ 7,775		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	108	$ 4,617	10-3	50
51	Licensed Practical Nurses	630	20,144	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	738	$ 24,761		53

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRISTINE HOPSON	ADMIN		$ 46,952
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 46,952

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 12,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 12,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		89,470
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 89,470

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 51,784
Unemployment Compensation Insurance		24,557
FICA Taxes		94,795
Employee Health Insurance		37,028
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		627
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		2,104
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		16,805
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 227,700

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,686
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,131
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,492
DUES & SUBSCRIPTIONS	361
MGMT CO ALLOCATION	28
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,405)
Yellow page advertising	(1,726)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,567

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	973
Seminar Expense	965
MGMT CO ALLOCATION	6,322
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,260

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **MO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees